

mailed validation letter  
10/26/11

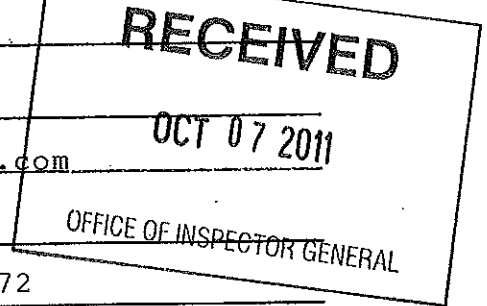
**Application for License to  
Operate a Long-term Care Facility**

For Office Use Only  
Received 10.7.11  
Amount \$1800.-

Ch#  
11430

**I. IDENTIFICATION**

Name Breathitt County Geriatric Corp. DBA  
Nim Henson Geriatric Center  
Address 420 Jett Drive  
City/County/Zip Jackson, Breathitt, 41339  
Telephone number (606)666-2456 fbach@setel.com  
Administrator Phillip Litteral  
Date facility operation began at current address July 1972  
Date facility began operation under current owner July 1972



| II. TYPE BEDS     | No. beds licensed | No. beds requested |
|-------------------|-------------------|--------------------|
| Skilled           | _____             | _____              |
| Nursing Home      | _____             | _____              |
| Nursing Facility  | <u>120</u>        | <u>120</u>         |
| Intermediate Care | _____             | _____              |
| ICF/MR            | _____             | _____              |
| Personal Care     | _____             | _____              |

**II. CONTROL (check one in each column)**

|  |           |             |
|--|-----------|-------------|
| State                                      | Profit    | Individual  |
| County <input checked="" type="checkbox"/> | Nonprofit | Partnership |
| City                                       |           | Corporation |
| Private                                    |           |             |

**II. OWNERSHIP**

Name and address of individual owner, partners or corporation. If partnership, list partners.

N/A

(OVER)

8/31

If facility owned or leased by a corporation, complete the following:

Name of corporation Breathitt County Geriatric Corporation

Address of corporation 420 Jett Drive

President or Chairman Arch Turner

Vice President Darrell Herald

Secretary \_\_\_\_\_

Treasurer \_\_\_\_\_

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

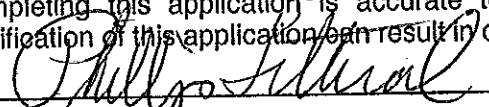
Parent

Management Company

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

  
\_\_\_\_\_  
Signature of authorized representative

Administrator 09/30/2011

Title

Date

Return Application and fee to:

Office of Inspector General  
275 East Main Street, 5E-A  
Frankfort, Kentucky 40621

OIG 5  
(10/2002)